NEIL ABERCROMBIE
GOVERNOR

STATE OF HAWAII
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HAWAII 96805-2121
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

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BARBARA CORIELL

November 22, 2011

TO: COBRA Participants of the State and Counties

FROM: Barbara Coriell, Administrator

SUBJECT: 2012 Health Plan Premium Rates and Open Enrollment for COBRA Participants

The Trustees of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) approved health plan premium rates for 2012. These premium rates and changes will be effective January 1, 2012.

An open enrollment period will be conducted from **November 23, 2011 through December 14, 2011** to provide you with an opportunity to make changes to your COBRA health plan enrollments if you wish to do so. Plan changes properly submitted during this open enrollment period will be effective January 1, 2012. Your completed form must be postmarked to EUTF **on or before December 14, 2011.** Please note that if you do NOT want to make changes you do NOT need to complete the COBRA Open Enrollment Form.

Also note that the HMA PPO will be insured with HMSA effective January 1, 2012. The plan (coverage) will remain the same but the administrator is changing from HMA to HMSA. If you are enrolled in the HMA plan and want to keep that plan, you do not need to fill out an enrollment form. Your enrollment will be automatically transferred from HMA to HMSA

Attachment #1 is a chart of EUTF COBRA Retirees effective January 1, 2012

Attachment #2 is a chart of the HSTA VB COBRA Retiree Rates effective January 1, 2012

Note: Separate invoices will be billed by each carrier selected.

Enclosed you will find the edited Retiree Reference Guide for January 1, 2012 – December 31, 2012 as well as the COBRA Open Enrollment Forms.

Can I change plans now?

Yes. Please fill out and submit the EUTF COBRA Election Form dated November 2011.

If I do not complete a Continuation of Coverage COBRA Election Form during the COBRA open enrollment period, will my health benefits terminate?

You do not need to complete a COBRA Election Form to continue your current coverage. However, if you did not make payment directly to the carriers (see page 3) by the first of the month, your coverage will be terminated. If you did make payment by the first of the month, your COBRA heath benefits will continue.

Will EUTF be conducting any open enrollment sessions that we can attend?

No.

I want to make a change and if I forget to check any box next to the various choices, what happens?

EUTF will assume you do not want (waive) that coverage.

If I do not want to make changes, do I still need to complete a COBRA Enrollment Form?

No.

If I want to make a change during the open enrollment, where do I send my completed COBRA Form?

Your completed form must be postmarked to EUTF on or before **December 14, 2011.**

Mail your completed forms to EUTF. Our mailing address is:

Hawaii Employer-Union Health Benefits Trust Fund
ATTN: COBRA Unit
P.O. Box 2121
Honolulu, HI 96815-2121

If I have questions, who can I contact?

We suggest you visit the EUTF website at eutf.hawaii.gov first to see if the information you need is available there. Click on the following links that may be pertinent:

- New COBRA Guidelines
- Links to Carrier Web Sites

If you still have questions, we prefer you email us your questions at: eutf@hawaii.gov. In the subject line type: "URGENT – COBRA INQUIRY". EUTF can answer your questions about eligibility, status of your enrollment, required supporting documents, and timing of submission of forms. However, if you have questions related to the **benefits** in any plan, we recommend you contact the applicable insurance carrier. Their contact information is:

- ChiroPlan:
  Honolulu (808) 621-4744, Neighbor Islands 1 (800) 414-8445
  711 Kilani Avenue, Suite 3, Wahiawa, HI 96786

- Hawaii Dental Service (HDS):
  (808) 529-9310, Toll-free 1 (866) 702-3883
  700 Bishop Street Suite 700, Honolulu, HI 96813

- Hawaii Medical Service Association (HMSA):
  Oahu (808) 948-6499, Toll-free 1 (800) 766-4672
  P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860

- Kaiser Permanente (Kaiser):
  (808) 432-5955, Toll-free 1 (800) 966-5955
  711 Kapiolani Boulevard, Honolulu, HI 96813

- informedRx [billing handled by ARM Ltd.]:
  Toll-free 1 (866) 533-6977
  ARM Ltd., 171 West Wing Street #210, Arlington Heights, IL 60005

- Vision Service Plan (VSP):
  Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162
  P.O. Box 997100, Sacramento, CA 95899

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
COBRA RETIREE RATES
EFFECTIVE JANUARY 1, 2012

Benefit Plan	Type of Enrollment	Total COBRA Premium
MEDICAL PLANS - MEDICARE		
PPO - 90/10 Medicare - HMSA Medical	Self	$179.40
	Two-Party	$349.62
	Family	$518.26
**Medicare Prescription Drug	Self	$207.61
	Two-Party	$404.24
	Family	$599.33
HMO Kaiser Medicare Medical Kaiser Prescription Drug	Self	$370.02
	Two-Party	$721.47
	Family	$1,069.20
MEDICAL PLANS - NON MEDICARE		
PPO - 90/10 Non Medicare- HMSA Medical	Self	$386.82
	Two-Party	$753.74
	Family	$1,117.41
**Non Medicare Prescription Drug	Self	$111.75
	Two-Party	$217.63
	Family	$322.69
HMO Kaiser Non Medicare Medical Kaiser Prescription Drug	Self	$670.18
	Two-Party	$1,306.82
	Family	$1,936.74
DENTAL PLAN		
HDS Dental	Self	$29.13
	Two-Party	$56.79
	Family	$69.65
VISION PLAN		
VSP Vision	Self	$5.16
	Two-Party	$10.32
	Family	$13.86

****The prescription drug rates are subject to increase depending on the outcome of the protest/appeal.**

Attachment #1

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
COBRA HSTA VB RETIREE RATES
EFFECTIVE JANUARY 1, 2012

Benefit Plan	Type of Enrollment	Total COBRA Premium
MEDICAL PLANS - MEDICARE		
PPO - 90/10 - HMSA	Self	$187.52
	Two-Party	$365.53
	Family	$541.84
**Prescription Drug	Self	$207.61
	Two-Party	$404.24
	Family	$599.33
HMO - Kaiser Medicare Medical, Drug	Self	$377.77
	Two-Party	$736.60
	Family	$1,091.69
MEDICAL PLANS - NON MEDICARE		
PPO - 90/10 - HMSA	Self	$401.82
	Two-Party	$782.93
	Family	$1,160.72
**Prescription Drug	Self	$117.52
	Two-Party	$228.86
	Family	$339.32
HMO - Kaiser Non Medicare Medical, Drug	Self	$684.26
	Two-Party	$1,334.24
	Family	$1,977.37
DENTAL PLAN		
HDS Dental	Self	$29.13
	Two-Party	$56.79
	Family	$69.65
VISION PLAN		
VSP Vision	Self	$5.16
	Two-Party	$10.32
	Family	$13.86
CHIROPRACTIC		
RSN Chiropractic	Self	$1.37
	Two-Party	$2.75
	Family	$2.91

****The prescription drug rates are subject to increase depending on the outcome of the protest/appeal.**

Attachment #2

EUTF-RETIREE COBRA NOV 2011	Hawaii Employer-Union Health Benefits Trust Fund **EUTF-RETIREE: COBRA OPEN ENROLLMENT FORM**	PLEASE SUBMIT THIS EUTF-RETIREE COBRA ELECTION FORM TO THE EUTF

SECTION 1: COBRA PARTICIPANT DATA

Please complete all applicable fields below.
Social Security numbers are required to process enrollments.

☐ Open Enrollment

COBRA Enrollee(Last Name, First Name, Middle Initial) _____

Social Security Number _____

Home Phone (_____) _____
Mobile Phone (_____) _____
Other Phone (_____) _____
Email _____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)
_____/_____/_____

COBRA Enrollee Residence Address
(☐ Check this box if your address has changed)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

COBRA Enrollee Mailing Address (if different from Mailing Residence Address)
(☐ Check this box if your address has changed)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

SECTION 2: COBRA PLAN SELECTION:

Make your slection selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family, or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.

☐ I (We) elect to continue coverage as indicated below and will be responsible for payment of the full cost of the selected coverage.

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical No Prescription Drug Coverage	☐	☐	☐	☐
	Prescription Drug (Not a valid selection w/ HMO)	☐	☐	☐	☐
HMO	HMO-**Kaiser** Medical (Includes Prescription Drug Coverage)	☐	☐	☐	☐
Other Plans		**Cancel/Waive**	**Self**	**2-Party**	**Family**
Dental	Hawaii Dental Service	☐	☐	☐	☐
Vision	Vision Service Plan	☐	☐	☐	☐

- Prescription Drug for some selections is billed separately.

COBRA PARTICIPANT'S SSN

SECTION 3: DEPENDENT INFORMATION AND ELECTION OF COBRA PLAN(S)

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification.

I certify that all of my dependent children meet eligibility requirements for enrollment in the COBRA plans. _____ **(initials)**

SECTION 4: COBRA PAYMENT INFORMATION

Checks are to be made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage and will not be reinstated. The monthly COBRA rates are subject to change in accordance with federal law.

Hawaii Medical Service Association (HMSA): Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	Vision Service Plan (VSP): Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162 P.O. Box 997100, Sacramento, CA 95899
InformedRx [billing handled by ARM Ltd.]: Toll-free: 1 (800) 533-6977 ARM Ltd., 171 West Wing Street #210, Arlington Heights, IL 60005	Royal State National Insurance Company (RSN): (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania St, Honolulu, HI 96813

SECTION 5: COBRA PARTICIPANT SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet COBRA's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for COBRA coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

COBRA Participant Signature: _____ Date Signed: _____

If you do not submit this completed Election Form by the due date, you will lose your right to elect COBRA continuation coverage.
If you reject COBRA continuation coverage before the due date, you may change your mind as long as you finish this completed Election Form before the due date.

HSTA-RETIREE COBRA NOV 2011	Hawaii Employer-Union Health Benefits Trust Fund **HSTA-RETIREE: COBRA OPEN ENROLLMENT FORM**	PLEASE SUBMIT THIS HSTA-RETIREE COBRA ELECTION FORM TO THE EUTF

SECTION 1: COBRA PARTICIPANT DATA

Please complete all applicable fields below.
Social Security numbers are required to process enrollments.

☐ Open Enrollment

COBRA Enrollee(Last Name, First Name, Middle Initial) _____

Social Security Number _____

Home Phone (_____) _____
Mobile Phone (_____) _____
Other Phone (_____) _____
Email _____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)
_____/_____/_____

COBRA Enrollee Residence Address
(☐ Check this box if your address has changed)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

COBRA Enrollee Mailing Address (if different from Mailing Residence Address)
(☐ Check this box if your address has changed)
Street_____
Line 2_____
City_____ State_____ Zip Code_____

SECTION 2: COBRA PLAN SELECTION:

Make your slection selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family, or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.

☐ I (We) elect to continue coverage as indicated below and will be responsible for payment of the full cost of the selected coverage.

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection Cancel/Waive	Self	Family
PPO	PPO-90/10 **HMSA** Medical, Prescription Drug, Vision, Chiro	☐	☐	☐
HMO	HMO-**Kaiser** Medical, (Includes Prescription Drug Coverage), Vision, Chiro	☐	☐	☐
Supplemental	Supplemental-**HMSA** Medical, Drug and Vision, Chiro	☐	☐	☐
Other Plans		**Cancel/Waive**	**Self**	**Family**
Dental	Hawaii Dental Service	☐	☐	☐
	Supplemental Hawaii Dental Service ***	☐	☐	☐
Vision	Vision Service Plan	☐	☐	☐

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

- Chiro is billed separately.
- Prescription Drug for some selections is billed separately.
- Vision for some selections is billed separately.

COBRA PARTICIPANT'S SSN _____

SECTION 3: DEPENDENT INFORMATION AND ELECTION OF COBRA PLAN(S)

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐
☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes. Dependent Certification and Student Certification.

I certify that all of my dependent children meet eligibility requirements for enrollment in the COBRA plans. _____ **(initials)**

SECTION 4: COBRA PAYMENT INFORMATION

Checks are to be made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage and will not be reinstated. The monthly COBRA rates are subject to change in accordance with federal law.

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Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813
Royal State National Insurance Company (RSN): (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania St, Honolulu, HI 96813	Vision Service Plan (VSP): Honolulu (808) 532-1600, Toll-free 1 (800) 522-5162 P.O. Box 997100, Sacramento, CA 95899

SECTION 5: COBRA PARTICIPANT SIGNATURE

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A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for COBRA coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

COBRA Participant Signature: _____ Date Signed: _____

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If you reject COBRA continuation coverage before the due date, you may change your mind as long as you finish this completed Election Form before the due date.